CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954

DATE: April 30, 2018

APPLICANT: Tennova Hospital – Cleveland
2305 Chambliss Ave.
Cleveland, TN 37311

CON# CN1803-015
CONTACT PERSON: Lisa Childers
2305 Chambliss Ave.
Cleveland, TN 37311

COST: $12,081,195

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:

The applicant, Cleveland Tennessee Hospital Company, LLC d/b/a Tennova Hospital-Cleveland (THC) proposes to establish a free standing emergency department (FSED). The proposed new facility will be a satellite emergency department, will have 8 treatment rooms and will include various supportive services such as CT, X-Ray, and ultra-sound. The proposed satellite emergency department will be located at 680 Stuart Road NE, Cleveland, TN 37312. The project does not involve additional inpatient beds, major medical services or initiation of new services for which a certificate of need is required.

THC is a 351 bed licensed acute care hospital with two campuses in Bradley County, TN. The main hospital is licensed for 251 inpatient beds, while the satellite campus, Tennova Hospital-Westside is licensed with 100 beds. The applicant proposes to establish a FSED to reduce the high capacity volumes at the main campus ED, while providing enhanced ED access to the patients in its service area. TeamHealth, the physicians group currently serving the main campus ED will also serve at the proposed FSED. TeamHealth staffs 60 FSEDs in fifteen states.

The satellite Emergency Department will be licensed as part of Tennova Hospital-Cleveland. The total project cost is $12,081,195 and will be funded through cash reserves.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

NEED:

The applicant's primary service area includes Bradley and Polk Counties.

2018-2022 Service Area Total Population Projections

County	2018	2022	% Increase or Decrease
Bradley	107,651	111,750	3.8%
Polk	17,627	17,977	2.0%
Total	125,278	129,727	3.0%

Tennessee Population Projections 2015 Revised UTCBER, Tennessee Department of Health

The applicant is seeking to reduce the high capacity volumes at their Tennova Cleveland ED. THC is the only provider of emergency services in the two county area. There are currently no approved but unimplemented emergency services in the service area. In 2015 and 2016, the THC ED served 50,533 and 48,331 patients, respectively. The vast majority of these ED patients resided in Polk and Bradley counties. Approximately 80% of ED patients were Bradley County residents, while about 9% were from Polk County in 2015. THC was the highest ED provider in Bradley County and the second highest ED provider in Polk County. Approximately 76% of the THC hospital admissions in 2016 were from Bradley County.

In October 2017, Copper Basin Medical Center in Polk County closed. With this closure, the residents of Polk County are expected to rely on the Tennova-Cleveland ED to serve their healthcare needs. These increases in future patient volumes will further strain the nearly full capacity at the THC ED.

The proposed room configuration in the FSED will be comprised of 6 Multi-purpose treatment rooms, 1 Isolation room, and 1 Trauma room. Combined with the main campus ED, a total of 49 ED treatment rooms are available for emergency services.

ED Utilization 2015-2016

	2015 Ed visits	2016 ED visits	2016 ED Rooms	2016 Visits/Room
Tennova Healthcare-Cleveland	50,533	48331	41	1179
*Copper Basin Medical Center	7,243	6,750	3	2250

*Joint Annual Reports of Hospitals, 2015-2016 Tenn*essee Department of Health, Division of Policy, Planning

*Copper Basin Medical Center is closed as of October, 2017.

2016 Service Area Acute Care Hospital Licensed and Staffed Bed Occupancy

Facility	Licensed Beds	Staffed Beds	Licensed Occupancy	Staffed Occupancy
Tennova Healthcare-Cleveland	251	155	39.5	64
Tennova Healthcare-Cleveland Westside	100	30	8.8	29.3
*Copper Basin Medical Center	25	25	39.6	39.6

Source: *Joint Annual Report of Hospitals 2016,* Division of Health Statistics, Tennessee Department of Health

*Copper Basin Medical Center is closed as of October, 2017.

Projected Satellite ED Visits Years 1 & 2

Total Visits	7,343	7,648
Total Rooms	8	8
Total Visits/Rooms	918	956

THC and Satellite ED Visits Years 1 & 2

Total Visits	47,453	47,872
Total Rooms	49	49
Total Visits/Rooms	968	977

TENNCARE/MEDICARE ACCESS:

The applicant participates in the Medicare (44-0185) and Medicaid/TennCare programs. The applicant contracts with TennCare MCOs AmeriGroup, United HealthCare Community Plan, BlueCare and TennCare Select. Further, the applicant serves a disproportionately high percentage of uninsured and Medicare patients. Approximately 16% of THC ED patients are uninsured.

The applicant's year one total gross Medicare revenue are projected to be $7,147,970 or 30% of total revenue and TennCare revenues are projected to be $7,147,970 or 30% of total gross operating revenues.

THC's Charity Care contingent was $2,311,103, .18% of gross operating revenue in 2016.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment have reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and if the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Funding for this project will be through an interest free cash transfer from the parent organization, Community Health Systems, Inc. A funding letter is included in Attachment B-EconFeas-B, with an estimated cost of $12,081,195.

The Cost Per Square Footage Chart is located on page 15 of the application detailing $454.39/Sq. Ft, higher than the 3rd quartile average cost. The applicant refers to their recently completed construction of an FSED in Clarksville, TN with cost per square foot being reasonable as compared with that project.

Project Costs Chart: The Project Costs Chart is located on page 70 of the application. The total project cost is $12,081,195, with $2,242,643 of moveable equipment. This includes CT unit, two x-ray units, ultrasound, electronic imaging system PACS, C-arm mobile x-ray, and GYN specific imaging.

Historical Data Chart: The Historical Data Chart is located in Supplemental 1 of the application. The applicant reported 50,533, 48,501, and 47,326 ED visits in 2015, 2016, and 2017 with net operating income of $4,150,308, $4,211,447, and 2,544,567 each year, respectively.

Projected Data Chart: The Projected Data chart is located in Supplemental 1 with ED visits of 7,343 for 2020, and 7,648 for 2021 with net operating income of $$26,301 and $74,298 each year, with 918 and 956 visits per room, respectively.

Proposed Charge Schedule

	Previous Year	Current Year	Year One	Year Two	% Change
Gross Charge	$3,304	$2,886	3,245	3,375	16.9%
Average Deduction	$3,040	$2,642	$2,777	$2,899	9.7%
Average Net Charge	$264	$244	$468	$476	95.1%

Project Payor Mix Year One

Payor Source	Projected Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	$7,147,970	30%
TennCare/Medicaid	$7,147,970	30%
Commercial/Other Managed Care	$5,480,110	23%
Self-Pay	$4,050,517	17%
Worker's Comp		
VA		
Charity Care		
Total	$23,826,567	100%

TeamHealth provides the emergency physicians certified in emergency medicine as an extension of the current contract in place at the main ED on the THC campus. Other FTEs are shown below.

Title	FTE

RNs	12.6
Respiratory Therapist	4.2
Medical Assistant	6.3
Manager	1.0
Nursing Aide	4.2
Lab Tech	4.2
Rad Tech	2.1
CT Tech	4.2
Security/Other	8.4

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
The proposed FSED location will be in north Cleveland, approximately 3 miles from the THC main campus and centrally located in the service area. The zip code, 37312, where the proposed ED would be located is the most populated and fastest growing in the two county service area. THC decided on establishing a FSED as the best option to reduce their main ED volumes. Expanding the main ED would require a temporary closure and completely disrupt patient care for ED services. This, plus the recent closure of Copper Basin medical center, would adversely affect the emergency care residents of Polk and Bradley would receive. The expansion of ED services will also ensure that patients will have access to health care closer to home rather than traveling to Chattanooga area hospitals. The THC FSED will provide 24/7, 365 day emergency services.

The parent company, Community Health Services, currently operates 9 FSEDs in the United States, of which the applicant will draw the expertise to operate the FSED.

The applicant states that as the only provider of emergency services in the two county service area, there will be now adverse effects on other providers.

The Project Completion Forecast Chart is located on page 96 of the application with a Final Project Report Form submitted on April 30, 2020.

QUALITY MEASURES:
The applicant is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities. The applicant is accredited by the Joint Commission.
Tennova Cleveland is also an accredited Chest Pain Center specific to emergency services.

The applicant also includes a copy of their Quality Assessment and Performance Improvement Program in the application.

On page 89 of the application, the applicant includes a list of educational facilities with which they have training affiliations.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

Freestanding Emergency Departments

The Health Services Development Agency (HSDA) may consider the following standards and criteria for applicants seeking to establish or expand Freestanding Emergency Departments (FSEDs). Rationale statements are provided for standards to explain the Division of Health Planning's underlying reasoning. Additionally, these rationale statements may assist stakeholders in responding to these Standards and may assist the HSDA in its assessment of applications. Existing FSEDs are not affected by these standards and criteria unless they take action that requires a new certificate of need (CON) for such services. These proposed standards and criteria will become effective immediately upon approval and adoption by the governor.

The Certificate of Need Standards and Criteria serve to uphold the Five Principles for Achieving Better Health set forth by the State Health Plan. These Principles were first developed for the 2010 edition and have been utilized as the overarching framework of the Plan in each annual update that has followed. Utilizing the Five Principles for Achieving Better Health during the development of the CON Standards and Criteria ensures the protection and promotion of the health of the people of Tennessee. The State Health Plan's Five Principles for Achieving Better Health are as follows:

1. **Healthy Lives:** The purpose of the State Health Plan is to improve the health of people in Tennessee.
2. **Access:** People in Tennessee should have access to health care and the conditions to achieve optimal health.
3. **Economic Efficiencies:** Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging value and economic efficiencies.
4. **Quality of Care:** People in Tennessee should have confidence that the quality of care is continually monitored and standards are adhered to by providers.
5. **Workforce:** The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

Definitions

Rural Area: A proposed service area shall be designated as rural in accordance with the U.S. Department of Health and Human Services (HRSA) Federal Office of Rural Health

Policy's *List of Rural Counties and Designated Eligible Census Tracts in Metropolitan Counties*. This document, along with the two methods used to determine eligibility, can be found at the following link:
http://www.hrsa.gov/ruralhealth/resources/forhpeligibleareas.pdf

For more information on the Federal Office of Rural Health Policy visit:
http://www.hrsa.gov/ruralhealth/

Freestanding Emergency Department: A facility that receives individuals for emergency care and is structurally separate and distinct from a hospital. A freestanding emergency department (FSED) is owned and operated by a licensed hospital. These facilities provide emergency care 24 hours a day, 7 days a week, and 365 days a year.

Service Area: Refers to the county or contiguous counties or Zip Code or contiguous Zip Codes represented by an applicant as the reasonable area in which the applicant intends to provide freestanding emergency department services and/or in which the majority of its service recipients reside.

Standards and Criteria

1. **Determination of Need:** The determination of need shall be based upon the existing access to emergency services in the proposed service area. The applicant should utilize the metrics below, as well as other relevant metrics, to demonstrate that the population in the proposed service area has inadequate access to emergency services due to geographic isolation, capacity challenges, or low-quality of care.

   The applicant shall provide information on the number of existing emergency department (ED) facilities in the service area, as well as the distance of the proposed FSED from these existing facilities. If the proposed service area is comprised of contiguous ZIP Codes, the applicant shall provide this information on all ED facilities located in the county or counties in which the service area ZIP Codes are located.

   The applicant should utilize Centers for Medicare and Medicaid Services (CMS) throughput measures, available from the CMS Hospital Compare website, to illustrate the wait times at existing emergency facilities in the proposed service area. Data provided on the CMS Hospital Compare website does have a three to six month lag. In order to account for the delay in this information, the applicant may supplement CMS data with other more timely data.

ED-1	Median time from ED arrival to ED departure for ED admitted

	patients
ED-2	Median time from admit decision to departure for ED admitted patients
OP-18	Median time from ED arrival to ED departure for discharged ED patients
OP-20	Door to diagnostic evaluation by a qualified medical professional
OP-22	ED-patient left without being seen

Capacity Challenges- Wait Times

Item	***Category***	***Tennova-Cleveland***	***Tennessee Average***	***National Average***
ED-1	*Median time from ED arrival to ED departure for ED admitted patients*	*401 mins*	*272 mins*	*297 mins*
ED-2	*Median time from admit decision to departure for ED admitted patients*	*206 mins*	*95 mins*	*121 mins*
OP-18	*Median time from ED arrival to ED departure for discharged ED patients*	*207 mins*	*170 mins*	*163 mins*
OP-20	*Door to diagnostic evaluation by a qualified medical professional*	*19 mins*	*19 mins*	*25 mins*
OP-22	*ED-patient left without being seen*	*5%*	*2%*	*2%*

The applicant should also provide data on the number of visits per treatment room per year for each of the existing emergency department facilities in the service area. Applicants should utilize applicable data in the Hospital Joint Annual Report to demonstrate the total annual ED volume and annual emergency room visits of the existing facilities within the proposed service area. All existing EDs in the service area should be operating at capacity. This determination should be based upon the annual visits per treatment room at the host hospital's emergency department (ED) as identified by the American College of Emergency Physicians (ACEP) in *Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition* as capacity for EDs. The capacity levels set forth by this document should be utilized as a *guideline* for describing the potential of a respective functional program. The annual visits per treatment room should exceed what is outlined in the ACEP document. Because the capacity levels set forth in the Emergency *Department Design: A Practical Guide to Planning for the Future, Second Edition* are labeled in the document as a "preliminary sizing chart", the applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients served within the existing ED facility in order to better demonstrate the need for expansion.

Table 9 – Supplemental Information
Visits Per Treatment Room in Existing ED Facilities in the Surrounding Area
Ranked from Highest to Lowest Total ED Visits, 2016

Emergency Department (Hospital)	County	Total Visits	# of ED Rooms	# of Visits per Room
Erlanger Medical Center	Hamilton	66,006	79	836
Parkridge East Hospital	Hamilton	50,430	19	2,654
CHI Memorial Hospital	Hamilton	49,445	31	1,595
Tennova Healthcare - Cleveland	**Bradley**	**48,501**	**41**	**1,183**
Starr Regional Medical Center - Athens	McMinn	39,297	N/A	N/A
Parkridge Medical Center	Hamilton	38,394	23	1,669
CHI Memorial Hixson	Hamilton	32,674	21	1,556
Erlanger East Hospital	Hamilton	31,197	17	1,835
Sweetwater Hospital Association	Monroe	25,528	15	1,702
Rhea Medical Center	Rhea	23,039	14	1,646
Erlanger North Hospital	Hamilton	14,857	8	1,857
Starr Regional Medical Ctr - Etowah	McMinn	11,000	9	1,222
Copper Basin Med Ctr *(now closed)*	**Polk**	**6,750**	**3**	**2,250**

Source & Notes:
2016 Joint Annual Report of Hospitals (JARs).
N/A = data not available in the 2016 JAR.

Source: https://www.medicare.gov/hospitalcompare/search.html

https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

If the applicant is demonstrating low-quality care provided by existing EDs in the service area, the applicant shall utilize the Joint Commission's "Hospital Outpatient Core Measure Set". These measures align with CMS reporting requirements and are available through the CMS Hospital Compare website. Full details of these measures can be found in the Joint Commission's *Specification Manual for National Hospital Outpatient Department Quality Measures*. Existing emergency facilities should be in the bottom quartile of the state in the measures listed below in order to demonstrate low-quality of care.

OP-1	Median Time to Fibrinolysis
OP-2	Fibrinolytic Therapy Received Within 30 Minutes
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4	Aspirin at Arrival
OP-5	Median Time to ECG
OP-18	Median Time from ED Arrival to Departure for Discharged ED Patients
OP-20	Door to Diagnostic Evaluation by a Qualified Medical Personnel
OP-21	ED-Median Time to Pain Management for Long Bone Fracture

OP-23	ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival

The applicant is not demonstrating low-quality care provided by Existing Emergency Departments.

Sources: https://www.jointcommission.org/hospital_outpatient_department/

https://www.jointcommission.org/assets/1/6/HAP_Outpatient_Dept__Core_Measure_Set.pdf

https://www.medicare.gov/hospitalcompare/search.html

https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

The HSDA should consider additional data provided by the applicant to support the need for the proposed FSED including, but not limited to, data relevant to patient acuity levels, age of patients, percentage of behavioral health patients, and existence of specialty modules. These data may provide the HSDA with additional information on the level of need for emergency services in the proposed service area. If providing additional data, applicants should utilize Hospital Discharge Data System data (HDDS) when applicable. The applicant may utilize other data sources to demonstrate the percentage of behavioral health patients but should explain why the alternative data source provides a more accurate indication of the percentage of behavioral health patients than the HDDS data.

THC serves a disproportionately high percentage of high-acuity, uninsured, and Medicare patients compared to the total ED patient population of the service area.

Table 8
Tennova Cleveland serves a Disproportionately High Percentage of High-Acuity Patients Compared to Total Service Area ED Patients
Acuity Levels are Ranked Lowest (Level 1) to Highest (Level 5)

Acuity Level *(Lowest to Highest)*	CPT Code	Tennova Cleveland Total ED Visits			Total ED Visits for Defined Service Area, 2015	
		CY15	CY16	CY17	Bradley & Polk Counties	ZIP Codes in 2-Counties
Level 1	99281	4.1%	3.4%	3.1%	4.3%	4.3%
Level 2	99282	7.5%	6.4%	6.9%	12.0%	12.2%
Level 3	99283	28.3%	26.2%	26.5%	33.6%	33.7%
Level 4	99284	30.8%	31.8%	30.9%	32.1%	32.1%
Level 5	**99285**	**29.3%**	**32.2%**	**32.6%**	**17.9%**	**17.8%**
Total		100.0%	100.0%	100.0%	100.0%	100.0%

Sources & Notes:
TDOH, Division of Policy, Planning and Assessment; and Tennova Cleveland internal data.
Please refer to Table 5 for the complete listing of ZIP Codes in the 2-county service area.

Please note: The acuity levels indicated in the table above and throughout the application are based on the above-indicated CPT evaluation and management ("E&M") billing codes, with Level 4 and 5 codes indicating patients with more complex, resource-intensive conditions.

Notably, Tennova Cleveland's use of CPT billing codes to categorize ED patient acuity is consistent with prior applications of Blount Memorial Hospital (CN1603-011) and Gateway Medical Center at Sango (CN1507-027). In both of those previously-approved applications, Level 1 corresponded to CPT Code 99281 (lowest acuity patient) and Level 5 corresponded to CPT Code 99285, highest acuity patient. Moreover, the use of CPT Codes to indicate patient severity/acuity is also consistent with data provided by TDOH.

The use of CPT Codes to categorize the severity of ED patients differs, however, from the Emergency Severity Index ("ESI") ranking of acuity which categorizes ED patients at the time of triage. The ESI ranking is *reverse* of the use of CPT Codes in categorizing patient acuity, with the ESI Level 1 representing the highest acuity and Level 5 representing the lowest. Specifically, ESI ranking at the time of patient triage ranges from Level 1-resuscitation, 2-emergent, 3-urgent, 4-less urgent to Level 5-non-urgent (or lowest acuity).

Table 9
Tennova Cleveland serves a Disproportionately High Percentage of Uninsured Patients Compared to Total Service Area ED Patients

	Tennova Cleveland Total ED Visits			Total ED Visits for Defined Service Area, 2015	
Payer Mix	CY15	CY16	CY17	Bradley & Polk Counties	ZIP Codes in 2-Counties
Commercial	21.9%	22.4%	22.4%	35.1%	35.0%
TennCare	32.0%	31.2%	30.2%	30.8%	30.8%
Medicare	28.7%	29.5%	29.9%	23.0%	23.0%
Other Govt.	1.0%	1.2%	1.2%	0.0%	0.0%
Self-Pay (Uninsured)	**16.3%**	**15.6%**	**16.3%**	**4.5%**	**4.6%**
Unknown	0.0%	0.0%	0.0%	6.6%	6.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

Sources & Notes:
TDOH, Division of Policy, Planning and Assessment; and Tennova Cleveland internal data.
Please refer to Table 5 for the complete listing of ZIP Codes in the 2-county service area.
TDOH payer mix categories include the following: Self-Pay includes free care; Medicaid includes TennCare plus CoverTN, Cover Kids, and Access TN.
Tennova Cleveland Medicare payer mix includes dual-eligible patients, thus includes patients ages 65+ as well as some patients under 65.

Table 10
Additional Data to Demonstrate Need in the Proposed Service Area

Emergency Department	% of Behavioral Health Patients	Statewide Average	% of High Acuity Patients*	Service Area Average**	% of Patients Ages 65+	Statewide Average
Tennova Cleveland	4.5%	N/A	63.5%	50.0%	20.4%	N/A

Sources & Notes:
Tennova Cleveland internal data. Data is for CY2017.
*Includes high acuity Levels 4 and 5 (*see* Table 8).
**Service area average information (2015) provided for reference; data from TDOH.

Resident County	Total	Number Behavioral Health Patients	Percentage Behavioral Health Patients	Number Patients Level I or II	Percentage Patients Level I or II	Number Patients Age 65 and Older	Percentage Patients Age 65 and Older
TENNESSEE	3,055,244	54,581	1.8	1,456,976	47.7	441,123	14.4
Bradley	49,697	1,074	2.2	29,702	59.8	8,952	18.0
Tennova-Cleveland	46,597	1,059	2.3	20,609	64.0	8,861	19.0

Source: Tennessee Department of Health, Division of Health Planning.
Hospital Discharge Data System, 2016. Nashville, TN.

See Standard 2, Expansion of Existing Emergency Department Facility, for more information on the establishment of a FSED for the purposes of decompressing volumes and reducing wait times at the host hospital's existing ED.

Note: Health Planning recognizes that limitations may exist for specific metrics listed above. When significant limitations exist (e.g. there are not adequate volumes to evaluate) applicants may omit these metrics from the application. However, the application should then discuss the limitations and reasoning for omission. Applicants are encouraged to supplement the listed metrics with additional metrics that may provide HSDA with a more complete representation of the need for emergency care services in the proposed service area.

Rationale: Applicants seeking to establish a FSED should demonstrate need based on barriers to access in the proposed service area. While limited access to emergency services due to geographic isolation, low-quality of care, or excessive wait times are pertinent to the discussion, the applicant is also encouraged to provide additional data from the proposed service area that may provide the HSDA with a more comprehensive picture of the unique needs of the population that would be served by the FSED. Host hospitals applying to establish a FSED displaying efficiencies in care delivery via high volumes and low wait time should not be penalized in the review of this standard. Host hospitals are expected to demonstrate high quality care in order to receive approval. See Standard 4 for more information.

Applicants seeking to establish an FSED in a geographically isolated, rural area should be awarded special consideration by the HSDA.

2. **Expansion of Existing Emergency Department Facility:** Applicants seeking expansion of the existing host hospital ED through the establishment of a FSED in order to decompress patient volumes should demonstrate the existing ED of the host hospital is operating at capacity. This determination should be based upon the annual visits per treatment room at the host hospital's emergency department (ED) as identified by the American College of Emergency Physicians (ACEP) in *Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition* as capacity for EDs. The capacity levels set forth by this document should be utilized as a *guideline* for describing the potential of a respective functional program. The applicant shall utilize the applicable data in the Hospital Joint Annual Report to demonstrate total annual ED volume and annual emergency room visits. The annual visits per treatment room should exceed what is outlined in the ACEP document. Because the capacity levels set forth in the Emergency *Department Design: A Practical Guide to Planning for the Future, Second Edition* are labeled in the document as a "preliminary sizing chart", the applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients served within

the existing ED facility in order to better demonstrate the need for expansion. See Standard 1, Demonstration of Need, for examples of additional evidence.

ED Utilization 2015-2016

	2015 Ed visits	***2016 ED visits***	***2016 ED Rooms***	***2016 Visits/Room***
Tennova Healthcare-Cleveland	***50,533***	***48331***	***41***	***1179***
****Copper Basin Medical Center***	***7,243***	***6,750***	***3***	***2250***

Joint Annual Reports of Hospitals, 2015-2016 Tennessee Department of Health, Division of Policy, Planning

****Copper Basin Medical Center is closed as of October, 2017.***

Table 12
Tennova Cleveland (Host Hospital) ED Visits Per Treatment Room

Emergency Department Design: A Practical Guide to Planning, American College of Emergency Physicians – Estimates for Emergency Department Areas and Beds

Most Recent Year Annual Visits (2017)	Dept. Gross Area	Bed Quantities		
	Low, Medium, or High Range	Low, Medium, or High Range Bed Qty.	Low, Medium, or High Range Visits/Beds	Estimated Area/Bed
47,326	High	40	1,250	850

Table 13 Tennova Cleveland CY17 Factors Supporting Appropriateness of ACEP *High Range Guideline*	
Factor	**Result**
% Emergency Department Patients Admitted as Inpatients	13.5%
Length of Stay (Hours) in ED	4.46
% of ED Patients seen in Private Rooms	100%
% of patients that will be moved from patient rooms to inner waiting or results waiting areas	15%
% of observation and extended stay patient remaining in ED	4.7%
# Average Minutes an ED patient admitted as an inpatient remains in ED	131
Average turnaround time (minutes) for results for lab and imaging studies	115: lab 208: imaging
% of behavioral health ED patients	4.5%
% of ED patients either ESI 4 or 5	10.0%
% of ED patients Age 65+	20.4%
% of imaging studies performed in ED	55.3%
Provisions in ED for family consult/grieving rooms	Yes
Availability of geriatric specialty area	No
Availability of pediatric specialty area	Yes
Availability of prisoner/detention patient specialty area	No
Availability of administrative/teaching specialty area	No

Additionally, the applicant should discuss why expansion of the existing ED is not a viable option. This discussion should include any barriers to expansion including, but not limited to, economic efficiencies, disruption of services, workforce duplication, restrictive covenants, and issues related to access. The applicant should also provide evidence that all practical efforts to improve efficiencies within the existing ED have been made, including, but not limited to, the review of and modifications to staffing levels.

THC decided on establishing a FSED as the best option to reduce their main ED volumes. Expanding the main ED would require a temporary closure and completely disrupt patient care for ED services. This, plus the recent closure of Copper Basin medical center, would adversely affect the emergency care residents of Polk and Bradley would receive. The expansion of ED services will also ensure that patients will have access to health care closer to home rather than traveling to Chattanooga area hospitals.

Applicants seeking to decompress volumes of the existing host hospital ED should be able to demonstrate need for the additional facility in the proposed service area as defined in the application in accordance with Standard 1, Determination of Need.

3. **Relationship to Existing Similar Services in the Area:** The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall include the likely impact of the proposed FSED on existing EDs in the service area and shall include how the applicant's services may differ from existing services. Approval of the proposed FSED should be contingent upon the applicant's demonstration that existing services in the applicant's proposed geographical service area are not adequate and/or there are special circumstances that require additional services.

RESPONSE: Tennova Cleveland is the only ED provider in the service area. Nonetheless, the following analyses include utilization information for hospitals in the surrounding area, including Hamilton County. As demonstrated below, service area residents rely on Tennova Cleveland for emergency services. The community's reliance on its local hospital supports the proposed project. As the sole community provider in the service area, Tennova Cleveland seeks permission to expand its existing ED through establishment of a FSED in the most populated and fastest-growing area of the county.

The proposed project is needed to enhance quality of care and access to emergency services for Tennova Cleveland's current and projected ED patients, including Polk County ED patients who must now travel outside of their home county for care since Copper Basin Medical Center closed. Tennova Cleveland's proposed ED expansion project, to be accomplished through the development of a satellite ED facility, will have no adverse impact on any existing provider.

Table 19
Hospital ED Utilization in the Proposed Service Area (PSA) and all Hamilton County EDs
Ranked Highest to Lowest for Bradley County ED Visits, 2015

Hospital	Bradley Co. ED Visits	% of Bradley Visits	Polk Co. ED Visits	% of Polk Visits	Total PSA ED Visits	Total Market Share
Tennova Healthcare - Cleveland	**35,108**	**77.6%**	**2,886**	**28.9%**	**37,994**	**68.8%**
Erlanger Medical Center	3,647	8.1%	483	4.8%	4,130	7.5%
CHI Memorial Hospital	1,608	3.6%	164	1.6%	1,772	3.2%
Erlanger East Hospital	1,337	3.0%	72	0.7%	1,409	2.6%
Starr Regional Med Ctr - Athens	957	2.1%	626	6.3%	1,583	2.9%
Parkridge Medical Center	664	1.5%	52	0.5%	716	1.3%
Parkridge East Hospital	631	1.4%	0	0.0%	631	1.1%
Other Hospitals*	524	1.2%	238	2.4%	762	1.4%
Starr Regional Med Ctr - Etowah	278	0.6%	1,713	17.1%	1,991	3.6%
CHI Memorial Hixson	202	0.4%	0	0.0%	202	0.4%
Rhea Medical Center	110	0.2%	0	0.0%	110	0.2%
Erlanger North Hospital	65	0.1%	0	0.0%	65	0.1%
Copper Basin Medical Ctr *(closed)*	**64**	**0.1%**	**3,756**	**37.6%**	**3,820**	**6.9%**
Sweetwater Hospital Association	60	0.1%	0	0.0%	60	0.1%
Total	**45,255**	**100.0%**	**9,990**	**100.0%**	**55,245**	**100.0%**

Source: TDOH, Division of Policy, Planning and Assessment.
*Note: Other Hospitals include all hospitals with 50 or less ED visits from the PSA counties.

Rural: The applicant should provide patient origin data by ZIP Code for each existing facility as well as the proposed FSED in order to verify the proposed facility will not negatively impact the patient base of the existing rural providers. The establishment of a FSED in a rural area should only be approved if the applicant can adequately demonstrate the proposed facility will not negatively impact any existing rural facilities that draw patients from the proposed service area. Additionally, in an area designated as rural, the proposed facility should not be located within 10 miles

of an existing facility. Finally, in rural proposed service areas, the location of the proposed FSED should not be closer to an existing ED facility than to the host hospital.

4. **Host Hospital Emergency Department Quality of Care:** Additionally, the applicant shall provide data to demonstrate the quality of care being provided at the ED of the host hospital. The quality metrics of the host hospital should be in the top quartile of the state in order to be approved for the establishment of a FSED. The applicant shall utilize the Joint Commission's hospital outpatient core measure set. These measures align with CMS reporting requirements and are available through the CMS Hospital Compare website. Full details of these measures can be found in the Joint Commission's *Specification Manual for National Hospital Outpatient Department Quality Measures*.

OP-1	Median Time to Fibrinolysis
OP-2	Fibrinolytic Therapy Received Within 30 Minutes
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4	Aspirin at Arrival
OP-5	Median Time to ECG
OP-18	Median Time from ED Arrival to Departure for Discharged ED Patients
OP-20	Door to Diagnostic Evaluation by a Qualified Medical Personnel
OP-21	ED-Median Time to Pain Management for Long Bone Fracture
OP-23	ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival

Table 22 Quality of Care Provided at the Host Hospital ED 4/1/2016 to 3/31/2017					
Measure		Tennova Healthcare - Cleveland	Tennessee Average	National Average	Comparison to National Average
Tennova Cleveland Emergency Department Volume Designation**		High	N/A	N/A	
OP-1	Median Time to Fibrinolysis	N/A	22 Minutes	28 Minutes	N/A
OP-2	Fibrinolytic Therapy Received Within 30 Minutes	N/A	71%	57%	N/A
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention	42 Minutes	53 Minutes	58 Minutes	Exceeded Benchmarks
OP-4	Aspirin at Arrival	100%	96%	95%	Top 10%
OP-5	Median Time to ECG	4 Minutes	6 Minutes	7 Minutes	Top 10%
OP-18	Median Time from ED arrival to ED Departure for Discharged ED Patients	207 Minutes	170 Minutes	163 Minutes	Did Not Meet Benchmarks
OP-20	Door to Diagnostic Evaluation by a Qualified Medical Professional	19 Minutes	19 Minutes	25 Minutes	Met or Exceeded Benchmarks
OP-21	ED-Median Time to Pain Management for Long Bone Fracture	94 Minutes	47 Minutes	49 Minutes	Did Not Meet Benchmarks
OP-22	ED-Patient Left Without Being Seen	5%	2%	2%	Did Not Meet Benchmarks
OP-23	ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	88%	74%	72%	Exceeded Benchmarks
Source: Medicare.gov Hospital Compare website; March 2018. **Note: High-volume Emergency Department providers serve 40,000 - 59,999 patients annually.					

Sources: https://www.jointcommission.org/hospital_outpatient_department/

https://www.jointcommission.org/assets/1/6/HAP_Outpatient_Dept__Core_Measure_Set.pdf

https://www.medicare.gov/hospitalcompare/search.html

https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

Note: Health Planning recognizes that limitations may exist for specific metrics listed above. When significant limitations exist (e.g. there are not adequate volumes to evaluate) applicants may omit these metrics from the application. However, the application should then discuss the limitations and reasoning for omission. Applicants are encouraged to supplement the listed metrics with additional metrics that may provide HSDA with a more complete representation of the need for emergency care services in the proposed service area.

5. **Appropriate Model for Delivery of Care:** The applicant should discuss why a FSED is the appropriate model for delivery of care in the proposed service area

RESPONSE: Tennova Cleveland's proposed FSED offers several distinct advantages over convenient care centers (*e.g.*, urgent care and retail clinics):

(1) **Willingness and ability to care for high-acuity patients**.
The FSED will care for patients with all acuity levels and illnesses, providing the necessary staff (*e.g.*, physicians), resources (*e.g.*, laboratory), and equipment (*e.g.*, CT) to provide care to all patients in need of emergency services. This is in direct contrast to retail clinics and urgent care centers that primarily, if not entirely, offer low-acuity and wellness (*e.g.*, immunizations) services.

(2) **Willingness and ability to care for uninsured patients**.
Tennova Cleveland's FSED will provide a needed patient access point for uninsured and underinsured patients, two groups of patients that urgent care and retail clinics do not typically serve. To illustrate, approximately 16% of Tennova Cleveland's ED visits annually are for uninsured (self-pay) patients compared to the approximate 5% of Bradley and Polk County total ED patients who are uninsured. Though data is not available on the payer mix of patients seeking care at convenient care centers, convenient care centers typically serve insured patients.

Moreover, Tennova Cleveland's proposed FSED will offer all emergency patients, including uninsured and underinsured (*e.g.*, TennCare) patients, the ability to access a smaller, dedicated outpatient campus that is easier to navigate than the hospital's larger, more complex main hospital campus.

(3) **Willingness and ability to provide care to patients 24 hours per day, 7 days per week, 365 days per year**.
Retail clinics and urgent care centers are typically open limited hours, usually from 7am until late evening (almost always no later than midnight), with even more limited hours on the weekend (Saturday and Sunday). Conversely, Tennova Cleveland's FSED will be open 24/7/365, just as its main campus ED is always open and ready to serve patients anytime they need emergency care.

(4) **Provision of care by board-certified and/or board-eligible physicians**.
The FSED will be staffed by physicians, which directly contrasts with retail and urgent care clinics that almost always, if not always, are staffed by physician extenders ("mid-levels"), *i.e.*, Nurse Practitioners and Physicians Assistants.

Specifically, Tennova Cleveland will staff the proposed FSED with board-certified and/or board-eligible TeamHealth physicians, which is the emergency physician group that currently cares for patients at Tennova Cleveland's main hospital campus ED.

6. **Geographic Location:** The FSED should be located within a 35 mile radius of the hospital that is the main provider.

The proposed FSED is located approximately 3 miles from the THC main campus.

Table 2
Driving Distance and Minimum Drive Time from Proposed FSED to Area Hospitals

Hospital	City	County	Miles *One-Way*	Free Flow Driving Time *One-Way*
Tennova Healthcare - Cleveland	Cleveland	Bradley	2.9	7 min
Erlanger East Hospital	Chattanooga	Hamilton	25.2	29 min
Starr Regional Med Ctr - Athens	Athens	McMinn	25.7	30 min
Starr Regional Med Ctr - Etowah	Etowah	McMinn	27.2	38 min
Rhea Medical Center	Dayton	Rhea	29.7	40 min
Parkridge East Hospital	Chattanooga	Hamilton	30.0	31 min
Parkridge Medical Center	Chattanooga	Hamilton	32.2	36 min
CHI Memorial Hospital	Chattanooga	Hamilton	32.8	37 min
CHI Memorial Hospital Hixson	Hixson	Hamilton	32.8	33 min
Erlanger Medical Center	Chattanooga	Hamilton	35.2	40 min
Erlanger North Hospital	Chattanooga	Hamilton	36.6	41 min
Sweetwater Hospital Association	Sweetwater	Monroe	39.2	40 min

Source: Google Maps.
Note: Driving times and free-flow distances based on the proposed FSED site address of 600 Stuart Road NE, Cleveland, TN, 37312.

7. **Access:** The applicant must demonstrate an ability and willingness to serve equally all of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access to ED services in the proposed Service Area.

The applicant commits to continue to serve equally all of the service area, Bradley and Polk Counties. THC serves all residents within the service area equally regardless of economic status.

8. **Services to High-Need Populations:** Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are uninsured, low income, or patients with limited access to emergency care.

THC serves a disproportionately high percentage of high-acuity, uninsured, and Medicare patients compared to the total ED patient population of the service area.

Patient Mix by County Service Area, by Select CPT Codes, 2015

CPT Code	Resident County						Total
	BRADLEY	HAMILTON	MCMINN	MEIGS	POLK	RHEA	
99281	1,958	5,149	1,913	379	268	1,786	11,453
99282	5,408	37,173	9,061	1,516	815	2,506	56,479
99283	15,002	65,184	15,510	2,886	2,338	8,748	109,668
99284	14,574	41,511	9,936	2,112	2,021	6,694	76,848
99285	8,185	14,357	4,279	828	1,080	1,135	29,864
Total	45,127	163,374	40,699	7,721	6,522	20,869	284,312

Project Payor Mix Year One

Payor Source	Projected Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	$7,147,970	30%
TennCare/Medicaid	$7,147,970	30%
Commercial/Other Managed Care	$5,480,110	23%
Self-Pay	$4,050,517	17%
Worker's Comp		
VA		
Charity Care		
Total	$23,826,567	100%

9. **Establishment of Non-Rural Service Area:** The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The applicant shall demonstrate the orderly development of emergency services by providing information regarding current patient origin by ZIP Code for the hospital's existing ED in relation to the proposed service area for the FSED.

Bradly County is a non-rural county. THC is the only hospital provider in the two county service area.

Establishment of a Rural Service Area: Applicants seeking to establish a freestanding emergency department in a rural area with limited access to emergency medical care shall establish a service area based upon need. The applicant shall demonstrate the orderly development of emergency services by providing information regarding patient origin by ZIP Code for the proposed service area for the FSED.

Polk County is a rural county. THC is the only hospital provider in the two county service area.

10. **Relationship to Existing Applicable Plans; Underserved Area and Population:** The proposal's relationship to underserved geographic areas and underserved population groups shall be a significant consideration.

Bradley and Polk Counties are designated in whole or in part as medically underserved areas

11. **Composition of Services:** Laboratory and radiology services, including but not limited to XRAY and CT scanners, shall be available on-site during all hours of operation. The FSED should also have ready access to pharmacy services and respiratory services during all hours of operation.

Laboratory, pharmacy, respiratory, and radiology services, including x-ray and CT will be available onsite during all hours of operation, 24/7.

12. **Pediatric Care:** Applicants should demonstrate a commitment to maintaining at least a Primary Level of pediatric care at the FSED as defined by CHAPTER 1200-08-30 Standards for Pediatric Emergency Care Facilities including staffing levels, pediatric equipment, staff training, and pediatric services. Applicants should include information detailing the expertise, capabilities, and/or training of staff to stabilize or serve pediatric patients. Additionally, applicants shall demonstrate a referral relationship, including a plan for the rapid transport, to at least a general level pediatric emergency care facility to allow for a specialized higher level of care for pediatric patients when required.

Nursing staff caring for pediatric patients at THC maintain a minimum of an associate degree in nursing and receive pediatric specific orientation and preceptorship upon employment. Each pediatric nurse is required to have Pediatric Advanced Life Support certification within 6 months of initial employment. Annual skill and age specific competency validations are required for all nursing staff. A copy of the TDOH Standards of Pediatric Emergency Care licensure survey is included in the application indicating no deficiencies.

In 2017, THC provided about 14.3% pediatric care as a percentage of its entire patient population.

13. **Assurance of Resources:** The applicant shall document that it will provide the resources necessary to properly support the applicable level of emergency services. Included in such documentation shall be a letter of support from the applicant's governing board of directors or Chief Financial Officer documenting the full commitment of the applicant to develop and maintain the facility resources,

equipment, and staffing to provide the appropriate emergency services. The applicant shall also document the financial costs of maintaining these resources and its ability to sustain them to ensure quality treatment of patients in the ED continuum of care.

Tennova Cleveland is committed to developing, maintaining, and staffing the proposed FSED in order to provide the appropriate level of emergency services at the facility.

14. **Adequate Staffing:** An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. Each applicant shall outline planned staffing patterns including the number and type of physicians and nurses. Each FSED is required to be staffed by at least one physician and at least one registered nurse at all times (24/7/365). Physicians staffing the FSED should be board certified or board eligible emergency physicians. If significant barriers exist that limit the applicant's ability to recruit a board certified or board eligible emergency physician, the applicant shall document these barriers for the HSDA to take into consideration. Applicants are encouraged to staff the FSED with registered nurses certified in emergency nursing care and/or advanced cardiac life support. The medical staff of the FSED shall be part of the hospital's single organized medical staff, governed by the same bylaws. The nursing staff of the FSED shall be part of the hospital's single organized nursing staff. The nursing services provided shall comply with the hospital's standards of care and written policies and procedures.

TeamHealth provides emergency physicians certified in emergency medicine as an extension of the current contract in place at the main ED on the THC campus. Other FTEs are shown below.

Title	*FTE*
RNs	*12.6*
Respiratory Therapist	*4.2*
Medical Assistant	*6.3*
Manager	*1.0*
Nursing Aide	*4.2*
Lab Tech	*4.2*
Rad Tech	*2.1*
CT Tech	*4.2*
Security/Other	*8.4*

Adequate Staffing of a Rural FSED: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. Each applicant shall outline planned staffing patterns

including the number and type of physicians. FSEDs proposed to be located in rural areas are required to be staffed in accordance with the Code of Federal Regulations Title 42, Chapter IV, Subchapter G, Part 485, Subpart F – Conditions of Participation: Critical Access Hospitals (CAHs). This standard requires a physician, nurse practitioner, clinical nurse specialist, or physician assistant be available at all times the CAH operates. The standard additionally requires a registered nurse, clinical nurse specialist, or licensed practical nurse to be on duty whenever the CAH has one or more inpatients. However, because FSEDs shall be in operation 24/7/365 and because they will not have inpatients, a registered nurse, clinical nurse specialist, or licensed practical nurse shall be on duty at all times (24/7/365). Additionally, due to the nature of the emergency services provided at an FSED and the hours of operation, a physician, nurse practitioner, clinical nurse specialist, or physician assistant shall be on site at all times.

Source: http://www.ecfr.gov/cgi-bin/text-idx?rgn=div6&node=42:5.0.1.1.4.4#se42.5.485_1631

Rationale: FSEDs should be staffed with a physician who is board-certified or board-eligible in emergency medicine and a registered nurse in order to ensure the facility is capable of providing the care necessary to treat and/or stabilize patients seeking emergency care. The HSDA should consider evidence provided by the applicant that demonstrates significant barriers to the recruitment a physician who is board-certified or board-eligible in emergency medicine exist.

Rural FSEDs should be awarded flexibility in terms of staffing in accordance with federal regulations. Additionally, flexibility in staffing requirements takes into account the limited availability of medical staff in certain rural regions of the state.

15. **Medical Records:** The medical records of the FSED shall be integrated into a unified retrieval system with the host hospital.

The proposed FSED will have an integrated medical records system between the existing main campus and the FSED campus.

16. **Stabilization and Transfer Availability for Emergent Cases:** The applicant shall demonstrate the ability of the proposed FSED to perform stabilizing treatment within the FSED and demonstrate a plan for the rapid transport of patients from the FSED to the most appropriate facility with a higher level of emergency care for further treatment. The applicant is encouraged to include air ambulance transport and an on-site helipad in its plan for rapid transport. The stabilization and transfer of emergent cases must be in accordance with the Emergency Medical Treatment and Labor Act.

The applicant includes a Patient Transfer Agreement with Erlanger Health System. The applicant has a Helicopter Medical Transportation Services Agreement with Air Evac EMS, Inc., however the FSED project does not include a helipad.

17. **Education and Signage:** Applicants must demonstrate how the organization will educate communities and emergency medical services (EMS) on the capabilities of the proposed FSED and the ability for the rapid transport of patients from the FSED to the most appropriate hospital for further treatment. It should also inform the community that inpatient services are not provided at the facility and patients requiring inpatient care will be transported by EMS to a full service hospital. The name, signage, and other forms of communication of the FSED shall clearly indicate that it provides care for emergency and/or urgent medical conditions without the requirement of a scheduled appointment. The applicant is encouraged to demonstrate a plan for educating the community on appropriate use of emergency services contrasted with appropriate use of urgent or primary care.

    The memorandum is available at the following link: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCletter08-08.pdf

THC plans to clearly indicate through signage and external communications that the proposed facility is an emergency department. The hospital's signage plan will reflect clear concise messaging to the services provided at the FSED.

18. **Community Linkage Plan:** The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health and outpatient behavioral health care system, including mental health and substance use, providers/services, providers of psychiatric inpatient services, and working agreements with other related community services assuring continuity of care. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of ED usage**.**

The applicant states that they provide significant community outreach to patients with mental Health and/or substance abuse needs, and working with agencies to provide alternatives to crisis management of patients in hospital EDs. THC provides a Behavioral Health Liaison who tries to address risk factors leading to the increased likelihood of ED usage in an attempt to reduce behavioral and substance abuse Ed usage.

THC also offers community health fairs and provides health screenings and flu shots.

Rationale: The State Health Plan moved from a primary emphasis of health care to an emphasis on "health protection and promotion". The development of primary prevention initiatives for the community advances the mission of the State Health Plan.

19. **Data Requirements:** Applicants shall agree to provide the Department of Health and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

The applicant agrees to provide all required TDOH and HSDA data.

20. **Quality Control and Monitoring:** The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. The FSED shall be integrated into the host hospital's quality assessment and process improvement processes.

The applicant provides a detailed Quality Assurance Plan in Attachment B-Need-A4.

21. **Provider-Based Status:** The applicant shall comply with regulations set forth by 42 CFR 413.65, *Requirements for a determination that a facility or an organization has provider-based status,* in order to obtain provider-based status. The applicant shall demonstrate eligibility to receive Medicare and Medicaid reimbursement, willingness to serve emergency uninsured patients, and plans to contract with commercial health insurers.

THC serves a disproportionately high percentage of high-acuity, uninsured, and Medicare patients compared to the total ED patient population of the service area.

Project Payor Mix Year One

Payor Source	Projected Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	$7,147,970	30%
TennCare/Medicaid	$7,147,970	30%
Commercial/Other Managed Care	$5,480,110	23%
Self-Pay	$4,050,517	17%
Worker's Comp		
VA		
Charity Care		
Total	$23,826,567	100%

22. **Licensure and Quality Considerations:** Any applicant for this CON service category shall be in compliance with the appropriate rules of the TDH, the EMTALA, along with any other existing applicable federal guidance and regulation. The applicant shall also demonstrate its accreditation status with the Joint Commission or other applicable accrediting agency. The FSED shall be subject to the same accrediting standards as the licensed hospital with which it is associated.

    THC is in good standing with the licensing, accrediting and certifying agencies.

    Note: Federal legislation, the Rural Emergency Acute Care Hospital (REACH Act), is under consideration. Under this legislation rural hospitals would be permitted to convert into a FSED and retain CMS recognition. If passage takes place, these standards should be considered revised in order to grant allowance to Tennessee hospitals seeking this conversion in accordance with the federal guidelines.